IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS
O'CONNELL, P.C., AND JANSEN AND MURRAY, JJ.

SHIRLEY HAMILTON, as Personal Representative of the Estate of ROSALIE ACKLEY, Deceased,

Plaintiff/Appellee,

v.

BLUE CROSS/BLUE SHIELD OF MICHIGAN

Intervening Plaintiff,

v.

MARK F. KULIGOWSKI, D.O.,

Defendant-Appellant

Supreme Court No: 126275

Court of Appeals No: 244126

Lower Court Case No: 00-033440-NH

APPELLANT'S BRIEF ON APPEAL -- APPELLANT MARK F. KULIGOWSKI, D.O.

ORAL ARGUMENT REQUESTED

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WITHIN THE MEANING OF MCLA § 600.2169(1)(a), DID ARNOLD MARKOWITZ, M.D. (AN INFECTIOUS DISEASE SPECIALIST), SPECIALIZE IN THE "SAME SPECIALTY" AS DEFENDANT/APPELLANT MARK KULIGOWSKI, D.O.?

Defendant/Appellant answers this question "No"

Plaintiff/Appellee answers this question "Yes"

The trial court answered this question "Yes"

The Court of Appeals did not explicitly address this issue.

QUESTION II

WITHIN THE MEANING OF MCLA § 600.2169(1)(b)(i), DID ARNOLD MARKOWITZ, M.D. (AN INFECTIOUS DISEASE SPECIALIST), DEVOTE A MAJORITY OF HIS PROFESSIONAL TIME TO THE ACTIVE CLINICAL PRACTICE OF GENERAL INTERNAL MEDICINE, DURING THE YEAR IMMEDIATELY PRECEDING THE OCCURRENCE INVOLVED IN THIS LITIGATION?

Defendant/Appellant answers this question "No"

Plaintiff/Appellee answers this question "Yes"

The trial court answered this question "No"

The Court of Appeals answered this question "No"

QUESTION III

DID THE COURT OF APPEALS ERR BY HOLDING THAT ARNOLD MARKOWITZ, M.D. (AN INFECTIOUS DISEASE SPECIALIST), WAS QUALIFIED TO OFFER TESTIMONY REGARDING THE STANDARD OF PRACTICE APPLICABLE TO A GENERAL INTERNIST, WHERE (1) THE WITNESS ADMITTED THAT HE WAS "NOT SURE WHAT THE AVERAGE INTERNIST SEES DAY IN OR DAY OUT", AND (2) NO TESTIMONY WAS OFFERED TO ESTABLISH THAT DR. MARKOWITZ WAS FAMILIAR WITH THE STANDARD OF CARE APPLICABLE TO A SPECIALIST IN GENERAL INTERNAL MEDICINE.

Defendant/Appellant answers this question "Yes"

Plaintiff/Appellee answers this question "No"

The trial court did not address this issue.

The Court of Appeals did not address this issue.

STATEMENT OF FACTS AND PROCEEDINGS

A. Introduction

This is a medical malpractice action. The patient was Rosalie Ackley. The treating physician was Defendant/Appellant Mark F. Kuligowski, D.O., who specializes in general internal medicine, with emphasis on the treatment of elderly patients. The Plaintiff claims that Dr. Kuligowski was professionally negligent by allegedly failing to: (1) identify Ms. Ackley as a patient at high risk for a stroke, and further failing to undertake a prompt work up for that disease; and (2) make an urgent referral of Ms. Ackley as of March 19, 1998, after she allegedly experienced pre-stroke symptoms. (Appendix, pp. 15a-16a: ¶13).[1] At the trial of this matter, Plaintiff offered the testimony of Arnold Markowitz, M.D. (a board certified internist who specializes in infectious diseases), regarding the standard of practice applicable to a specialist in general internal medicine. The testimony of Dr. Markowitz demonstrated that he devoted the majority of his professional time to the field of infectious diseases.

At issue on this appeal is the proper construction of MCLA § 600.2169 which states as follows, in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action **in the same specialty** as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered

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[1] Some of the documents contained in the Appendix have multiple numbered paragraphs, or multiple pages (reduced in size), on a single page. In these instances, in order to specify the particular paragraph or page that is being cited, the citation to the Appendix will be given in the following format: "(Appendix, pp. 15a-16a: ¶13)" or "(Appendix, p. 23a: 109-110)." In each instance, the number after the colon refers to the specific numbered paragraph or reduced page that is being cited.)

> as a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), **during the year immediately preceding the date of the occurrence** that is the basis for the claim or action, **devoted a majority of his or her professional time to** either or both of the following:
>
> (i) **The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.**
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty. (emphasis added).

Based upon this statute, the trial court precluded Dr. Markowitz from offering testimony regarding the standard of practice applicable to a specialist in general internal medicine. Plaintiff's counsel conceded that he had no other standard of practice experts besides Dr. Markowitz. Defendant/Appellant therefore moved for, and was granted, a directed verdict.

The Court of Appeals reversed the trial court, on the basis that both Dr. Kuligowski and Dr. Markowitz were board certified internists.

B. Plaintiff's Allegations

Plaintiff alleges that Rosalie Ackley became a patient of Dr. Kuligowski on August 13, 1992. (Appendix, pp. 14a-15a: ¶4). Plaintiff further alleges that over the next five and a half years, Ms. Ackley treated with Dr. Kuligowski for hypertension, diabetes, weight control, and a thyroid ailment. (Appendix, p. 15a: ¶5).

According to the Plaintiff, Ms. Ackley saw Dr. Kuligowski on March 19, 1998 with complaints of left arm numbness and weakness which had occurred twice within the past three days. (Appendix, p. 15a: ¶6; Appendix, p. 23a: 109-110; Appendix, p. 26a: 119). The

Plaintiff claims that, at the time of that visit, Ms. Ackley provided a history of blockages of the carotid arteries of her neck, as determined by Doppler ultrasound several years prior. (Appendix, p. 15a: ¶7; Appendix, p. 25a: 116-117). Plaintiff alleges that Dr. Kuligowski detected bilateral carotid artery bruits[2] on physical examination of Ms. Ackley. (Appendix, 15a: ¶7; Appendix, pp. 24a: 111 and 26a: 119), and that Dr. Kuligowski suspected a transient ischemic attack and bilateral carotid artery disease. (Appendix, pp. 15a: ¶8; Appendix, p. 26a: 120).

Plaintiff further maintains that Dr. Kuligowski ordered bilateral carotid Dopplers and an echocardiogram at Saginaw General Hospital, and advised Ms. Ackley and her daughter that there was no cause for immediate concern. (Appendix, p. 15a: 9). According to the Plaintiff, one of Ms. Ackley's daughters called Dr. Kuligowski on March 20, 1998, allegedly expressing concerns about her mother's symptoms, and Dr. Kuligowski allegedly advised her that there was no cause for immediate concern. (Appendix p. 15a: ¶10; Appendix, p. 26a: 121-122).

Plaintiff asserts that Ms. Ackley suffered a massive stroke three days later (Appendix, p. 15a: ¶11; Appendix, p. 26a: 122), and that she continued to suffer the sequelae of the stroke until her death in December, 2000. (Appendix, p. 16a: ¶14).

C. Proceedings in the Trial Court

The trial of this matter began on April 30, 2002. On May 3, 2002, the Plaintiff called Arnold Markowitz, M.D. as an expert regarding the standard of practice applicable to a specialist in internal medicine. (Appendix, pp. 41a-46a). He became board certified in internal medicine in 1974. (Appendix, p. 43a). He testified that following his training in internal medicine, he received additional training in infectious diseases. (Appendix, pp. 42a-43a). He described the

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[2] During his opening statement, Plaintiff's counsel defined a "bruit" as "the sound that the blood makes through a stethoscope when the artery has a blockage in it." (Appendix, 111).

additional training as including fevers, bacterial and viral infections, post-operative infections, wound infections, and how to use antibiotics. (Appendix, pp. 42a-43a).

Before Plaintiff's counsel elicited any standard of practice testimony from Dr. Markowitz, counsel for Dr. Kuligowski was given the opportunity to voir dire Dr. Markowitz regarding the nature of his specialization and practice. (Appendix, 46a-76a). It was undisputed that Defendant/Appellant Kuligowski and Dr. Markowitz are both board certified in internal medicine, but as shown below, that is where the similarity in their medical practices ends. Dr. Markowitz devotes the majority of his clinical practice to infectious diseases, whereas Dr. Kuligowski's clinical practice was as a general internist seeing patients in the office, "uniquely emphasizing in his practice geriatric patients or elderly patients" (Appendix, p 28a: 130), such as Plaintiff/Appellee's Decedent, Rosalie Ackley, age 73, a long term patient of Dr. Kuligowski (Appendix, p. 29a: 131).

Dr. Markowitz agreed that a specialist in general internal medicine, or internist, will treat many different systems of the body. (Appendix, p. 47a). The systems treated by a general internist include the heart, gastrointestinal tract, infections, lungs, genital urinary tract, and kidneys. (Appendix, p. 47a-48a). Indeed, Dr. Markowitz testified that one would be hard pressed to find a system that internists do not deal with. (Appendix, p. 47a).

Dr. Markowitz agreed that internal medicine can be a pathway to further specialization for some doctors. (Appendix, pp. 48a-51a). In that regard, Dr. Markowitz testified as follows:

> Q. And internal medicine, therefore, can serve as a pathway to subspecialties?
> A. Sure.
> Q. Okay. And, in fact, that's how you got to the point of being a subspecialist in infectious diseases, correct?
> A. Well, I'm an internist, an infectious disease person, it says so on my cards.
> Q. Well, infectious disease specialist by in large, if not universally, is first an internist and then takes additional training as you did following your internal medicine?

A. Most of the infectious disease medicine that – like I said, there are a couple guys who do infectious disease who are trained in other areas. Most of us start out as internists.
Q. All right. Now, people who start out as internists and go on to specialize in the heart are known as **cardiologists**, correct?
A. Yes.
Q. The people who start out as internists and go on to deal with the GI tract are called?
A. **Gastroenterologists**.
Q. I'm going to abbreviate that one a little bit. Those who start out with – as an internist but go on to specialize – get additional training in infectious disease are called **infectious disease doctors**?
A. We never did get good terminology.
Q. You didn't get a special term?
A. We didn't get a regular name.
Q. However, it's accepted as a special term?
A. That's true.
Q. Those that start as an internist and go on to the lungs are known as **pulmonologists**, correct?
A. Yes, or – well, there's a bunch of different names for pulmonary guys.
Q. There is a group of internists who go on to become **critical care physicians**?
A. Right.
Q. And that's a subspecialty?
A. Actually, yes. Maybe even a sub-subspecialty.
Q. It's boarded all by itself?
A. Yeah, but I – again, I am not sure what the pathway is to get to it. You might have to have a specialty, a subspecialty and then a sub-subspecialty.
Q. The internists who go on to specialize in kidneys are called **nephrologists**?
A. Yes. (Appendix, p 48a-50a)

He recognized rheumatology, neurology, dermatology, hematology, and oncology as among the other specialties which a physician may attain through further training following initial training and certification in internal medicine. (Appendix, 50a-51a).

Dr. Markowitz further acknowledged that internal medicine can be the end point of formal training and study for other physicians:

Q. The point being that internal medicine is a pathway. Internal medicine is an ending point for some doctors.

That's the end of your formal studies, you become an internist?

A. Yeah, in the formal training, yeah. Well, I guess it could be.

Q. I know you all have ongoing training, but internal medicine is an end point of formal studies for some physicians?

A. Can be. (Appendix, p. 51a)

General internal medicine was the end point of formal training for Defendant/Appellant Kuligowski, but barely an intermediary pause for Dr. Markowitz, who testified that he completed "additional subspecialty training", a fellowship in infectious diseases, after completing his internal medicine residency, and before entering private practice in 1976 (Appendix, p. 51a). Dr. Markowitz is not board certified in infectious diseases (Appendix, p. 69a).

Further voir dire of Dr. Markowitz established that the majority of his professional time was devoted to the clinical practice of infectious disease medicine, and not general internal medicine as practiced by Defendant/Appellant Kuligowski. Dr. Markowitz initially testified that the breakdown in his practice has been essentially the same since he began practice in 1976 (Appendix, p. 51a-52a), with roughly equal or lesser amounts of time spent in the office than at the hospital:

Q. You said your practice is half - half the time you spend in the office?

A. Right.

Q. How many hours is that?

A. That's three days a week part-time, so probably 15, 20 hours a week.

Q. Fifteen, 20 in the office. And then how many hours do you spend in the hospital per week?

A. It varies -- It's -- as a consultant its whatever I'm called, so it can be from 15 to 50 or so. (Appendix, p. 52)

. . . .

Q. Doctor, in this pattern of practice that has remained essentially the same since 1976, you spend half or more of your time at the hospital, true?

A. I believe so, yes. (Appendix, p. 57a)

Dr. Markowitz further testified that of the time spent in the office, about half of that was with general internal medicine patients, and the other half with infectious disease patients:

> Q. Your testimony was half the time that you spend in the office is seeing patients whose emphasis is internal medicine in the broader scope and half is treating patients whose emphasis is infectious disease?
> A. About, yeah. (Appendix, p. 53a)

Dr. Markowitz admitted that approximately 95% of the patients he sees in the hospital setting are infectious disease patients (Appendix, pp. 57a-58a). Counsel also confronted Dr. Markowitz with several depositions he had in other cases which were marked as Exhibits 26 - 29, and read in part into the record herein without objection (Appendix, pp. 67a-68a). In those cases, while being offered as an expert in infectious disease, Dr. Markowitz minimized the amount of time he spent in the office on general internal medicine matters to 6 or 8 hours a week (Appendix, p. 69a), and repeatedly admitted that the large majority of his hospital practice was infectious disease consultations:

> Q. Did you testify in the Eberts deposition that the ***majority of your practice was infectious disease?***
> A. Yes.
> Q. All right. Was it true when you said it?
> A. ***It's still true.***
> Q. Still true today?
> A. Yeah. (Appendix, pp. 64a-65a)
>
> . . . .
>
> Q. Have you ever testified under oath to the following breakdown in the division of your practice between internal medicine and infectious disease, that you spent 12-15 hours a week in the office, half of which is Internal Medicine, half of which is infectious disease? You spend 40 hours a week in a hospital-based practice, 95% of which is infectious disease?
> A. I think that's fundamentally what I said today. I think we went different hours in the office because I spend a little more time there now.

Q. So if I pull out a couple more depositions that said that, it would be unnecessary because your testimony today is you spend 95% of your hospital time in Infectious Disease?
A. That's correct. (Appendix, p. 65a)(emphasis added)

Dr. Markowitz further admitted that the average internist sees a broader scope of patients than a specialist in infectious diseases. (Appendix, p. 62a). When asked whether he sees a broader base of infectious disease issues than the average internist, Dr. Markowitz responded that "I'm not sure what the average internist sees day in or day out." (Appendix, p. 58a).

At the conclusion of the voir dire, counsel for Dr. Kuligowski moved to preclude Dr. Markowitz from testifying regarding the standard of practice applicable to Dr. Kuligowski, because he did not fulfill the requirements of MCLA § 600.2169. (Appendix, pp. 76a-87a). In response, Plaintiff's counsel argued that Dr. Markowitz satisfied MCLA § 600.2169 because both he and Dr. Kuligowski were board certified in internal medicine. (Appendix, pp. 87a-89a, 95a). In the course of his argument, Plaintiff's counsel conceded that, although Dr. Markowitz is a specialist in infectious diseases, this case does not present any infectious disease issues. (Appendix, pp. 87a-88a, 95a).

After allowing extensive argument by both counsel (Appendix, pp. 76a-96a), and even the proposed expert witness himself (Appendix, pp. 106a-111a), the trial court held that Dr. Arnold Markowitz fulfilled the requirements of MCLA § 600.2169(1)(a) because both he and Defendant/Appellant Kuligowski were board certified in internal medicine (Appendix, p 104a). In pertinent part, the trial court ruled as follows:

> "So the facts of this case, as I understand it, is that the act complained of of the Defendant Dr. Kuligowski is that he failed to order some tests done which would have prevented the stroke, the job of an internist. That is to say he was not acting in his specialty of gerentology but rather as an internist so, further, otherwise that – that is the recognized area of board certified internist. The witness being offered is likewise a board certified internist so 600.2169(a) is complied with. (Appendix, p. 104a).

The court also held, however, that Dr. Markowitz did not fulfill the requirements of MCLA § 600.2169(1)(b)(i), because Dr. Markowitz admitted that the majority of his clinical practice was as an infectious disease specialist, and not in general internal medicine (Appendix, pp. 105a-106a). In pertinent part, the trial court ruled as follows:

> "I don't find anything here that limits the term clinical practice to office practice or to hospital practice. I have to otherwise accept the, I think, plain meaning that active clinical practice covers whatever he is doing in connection with his practice of medicine, hospital or office.
>
> On that basis, it's apparent that he does not practice the majority of his time in the field of internal medicine but rather in the field of infectious disease, and following that reasoning that I don't have any choice but to follow the plain meaning of the statute, I will sustain the Defendant's objection to the witness' qualifications to express opinions as to the standard of care in the field of internal medicine." (Appendix, pp. 105a-106a)

Accordingly, the trial court ruled that Dr. Markowitz would not be allowed to testify regarding the standard of practice applicable to Dr. Kuligowski. (Appendix, p. 106a).

It is most interesting to note that the trial court, over objection by Defendant/Appellant but outside the presence of the jury, actually allowed Dr. Markowitz to plead his own case subsequent to the above ruling (Appendix, 106a-111a), with Dr. Markowitz, a "professional witness" to the end, even attempting in vain to argue the law and distinguish Decker v Flood, 248 Mich App 75, 638 NW2d 163 (2002), from the case at bar. Significantly, in the course of his effort to advocate for a broad construction of MCLA § 600.2169(1), Dr. Markowitz claimed that "I am better able to diagnose subspecialty areas because I spent more time with them than the average internist." (Appendix, p. 108a)

It is also of interest that Dr. Markowitz appeared in the published decisions in Nippa v Botsford Gen. Hosp, 251 Mich App 664, 651 NW2d (2002), vacated and remanded, 468 Mich. 882, 661 N.W.2d 231 (2003), on remand, 257 Mich.App. 387, 668 N.W.2d 628 (2003), holding

himself out as an expert and specialist in infectious disease, but not being allowed to offer testimony against a physician board certified in that specialty due to his lack of certification:

> "Although Dr. Markowitz specializes in infectious disease, he is not board-certified in this area of medicine." Nippa v Botsford Gen. Hosp, 251 Mich App 664, 666, 651 NW2d (2002).

Counsel for Plaintiff/Appellee conceded that without Dr. Markowitz, Plaintiff/Appellee could not establish a prima facie case, and did not oppose Defendant/Appellant's Motion for Directed Verdict (Appendix, pp. 111a-113a).

The trial court denied Plaintiff's motion for new trial. (Appendix, p. 122a).

D. Proceedings in the Court of Appeals

Plaintiff appealed to the Court of Appeals. Defendant/Appellant Kuligowski filed a timely Cross-Appeal, and argued that the trial court clearly erred by ruling that Dr. Markowitz was qualified to testify pursuant to MCLA § 600.2169(1)(a), simply because both he and Defendant/Appellant were board certified in internal medicine.

On April 22, 2004, the Court of Appeals issued an opinion reversing the trial court. (Appendix, pp. 123a-125a). In that opinion, the Court of Appeals did not explicitly address whether Dr. Markowitz fulfilled the requirements of MCLA § 600.2169(1)(a), which was the issue raised in Defendant's cross-appeal. Rather, the Court only addressed whether Dr. Markowitz met the requirements of MCLA § 600.2169(1)(b). The Court of Appeals held, in pertinent part, as follows:

> "In this case, defendant specialized in internal medicine, with a special emphasis on geriatric medicine. Dr. Markowitz also specialized in internal medicine, he simply focused on the different subspecialty of infectious diseases. . .
>
> Therefore, the record reflects that Dr. Markowitz devoted the majority of his professional time to the "active clinical practice" of defendant's internal medicine "specialty." The statute does not require more.

> We decline defendant's invitation to graft a requirement for matching subspecialties onto the plain "specialty" language of MCL 600.2169(1). By holding plaintiff's expert witness to a higher standard than the statute required, the trial court demonstrated its misapprehension of the law.
>
> Accordingly, the trial court abused its discretion when it struck Dr. Markowitz's testimony." (Appendix, pp. 124a-125a).

Defendant/Appellant Kuligowski filed a timely Application for Leave to Appeal to this Court. On July 12, 2005, this Court granted the Application for Leave to Appeal. (Appendix, p. 126a). In its order, this Court directed the parties to include among the issues to be briefed:

> (1) the proper construction of the words "specialist" and "that specialty" in MCL 600.2169(1)(a) and MCL 600.2169(1)(b)(i); and
>
> (2) the proper construction of "active clinical practice" and "active clinical practice of that specialty" as those terms are used in MCL 600.2169(1)(b)(i). (Appendix, pp. 126a).

ARGUMENT I

THE COURT OF APPEALS AND TRIAL COURT ERRED BY FINDING THAT, WITHIN THE MEANING OF MCLA § 600.2169(1)(a), ARNOLD MARKOWITZ, M.D. (AN INFECTIOUS DISEASE SPECIALIST), SPECIALIZED IN THE "SAME SPECIALTY" AS DEFENDANT/APPELLANT MARK KULIGOWSKI, D.O. (A SPECIALIST IN GENERAL INTERNAL MEDICINE).

A. Standard of Review

This issue involves a question of statutory construction. Issues of statutory construction are subject to the de novo standard of review. Taggart v. Tiska, 465 Mich. 665, 669, 641 N.W.2d 240, 243 (2002); Hanson v. Board of County Road Com'rs of County of Mecosta, 465 Mich. 492, 497, 638 N.W.2d 396, 399 (2002).

The cardinal rule of statutory interpretation is to give effect to the intent of the Legislature. Mayor of City of Lansing v. Michigan Public Service Com'n, 470 Mich. 154, 157, 680 N.W.2d 840, 842 (2004). When interpreting a statute, it is not the role of the judiciary to second-guess the wisdom of a legislative policy choice. State Farm Fire and Cas. Co. v. Old Republic Ins. Co., 466 Mich. 142, 149, 644 N.W.2d 715, 719 (2002). Rather, the judiciary's constitutional obligation is to interpret--not to rewrite--the law. State Farm Fire and Cas. Co. v. Old Republic Ins. Co., 466 Mich. 142, 149, 644 N.W.2d 715, 719 (2002).

The best measure of the Legislature's intent is the words that it has chosen to enact into law. Mayor of City of Lansing v. Michigan Public Service Com'n, 470 Mich. 154, 164, 680 N.W.2d 840, 846 (2004). A statutory term cannot be viewed in isolation, however, but must be construed in accordance with the surrounding text and the statutory scheme. Breighner v. Michigan High School Athletic Ass'n, Inc., 471 Mich. 217, 232, 683 N.W.2d 639, 648 (2004); Herald Co. v. City of Bay City, 463 Mich. 111, 130 fn. 10, 614 N.W.2d 873, 883 fn. 10 (2000). Courts must also give effect to every word, phrase, and clause in a statute, and must avoid an interpretation that would render any part of the statute surplusage or nugatory. Griffith ex rel.

Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521, 533, 697 N.W.2d 895, 902 (2005); State Farm Fire and Cas. Co. v. Old Republic Ins. Co., 466 Mich. 142, 146, 644 N.W.2d 715, 717 (2002).

Undefined statutory terms must be given their common, ordinary and generally accepted meanings. Bailey v. Oakwood Hosp. and Medical Center, 472 Mich. 685, 692-693, 698 N.W.2d 374, 379 (2005); Koontz v. Ameritech Services, Inc., 466 Mich. 304, 312, 645 N.W.2d 34, 39 (2002). In its effort to determine the commonly understood meaning of the statutory terminology, the judiciary may consult dictionary definitions when terms are not expressly defined by a statute. Griffith ex rel. Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521, 526, 697 N.W.2d 895, 898 (2005); Cox ex rel. Cox v. Board of Hosp. Managers for City of Flint, 467 Mich. 1, 18, 651 N.W.2d 356, 365 (2002); Koontz v. Ameritech Services, Inc., 466 Mich. 304, 312, 645 N.W.2d 34, 39 (2002).

If the language of the statute is clear and unambiguous, further judicial construction through the application of further interpretive aids is not permitted. Tyler v. Livonia Public Schools, 459 Mich. 382, 392, 590 N.W.2d 560, 564 (1999)(application of the "in pari materia" principle is not appropriate where the statutory language is unambiguous). A statute is ambiguous only if it irreconcilably conflicts with another provision, or when it is **equally** susceptible to more than a single meaning. Mayor of City of Lansing v. Michigan Public Service Com'n, 470 Mich. 154, 166, 680 N.W.2d 840, 847 (2004).

B. Analysis

MCLA § 600.2169(1)(a) required that Plaintiff/Appellee establish that Dr. Markowitz satisfied the following criteria:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

> (a) If the party against whom or on whose behalf the testimony is offered is a **specialist, specializes** at the time of the occurrence that is the basis for the action in the **same specialty** as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered as a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty."

In pertinent part, the trial court ruled as follows:

> "THE COURT: So the facts of this case, as I understand it, is that the act complained of of the Defendant Dr. Kuligowski is that he failed to order some tests done which would have prevented the stroke, the job of an internist. That is to say he was not acting in his specialty of gerentology but rather as an internist so, further, otherwise that - that is the recognized area of board certified internist. The witness being offered is likewise a board certified internist so 600.2169(a) is complied with. (Appendix, pp. 103a-104a).

In short, the trial court held that, within the meaning of MCLA § 600.2169(1)(a), Dr. Markowitz (a specialist in the field of infectious diseases) specialized in the "same specialty" as Dr. Kuligowski (a specialist in internal medicine) "at the time of the occurrence" involved in this action.

In the Court of Appeals, Defendant/Appellant Kuligowski filed a timely Cross-Appeal. In Argument II of his Court of Appeals Brief, Defendant/Appellant Kuligowski argued, as Cross-Appellant, that the trial court erred by holding that Dr. Markowitz fulfilled the requirements of MCLA § 600.2169(1)(a) simply because he and Dr. Kuligowski were board certified in internal medicine. The Court of Appeals opinion does not directly address this issue, or even acknowledge the existence of the cross appeal. By implication, the Court rejected this argument by the following broad and erroneous construction of MCLA § 600.2169(1)(b)(i):

> "In this case, defendant specialized in internal medicine, with a special emphasis on geriatric medicine. Dr. Markowitz also specialized in internal medicine, he simply focused on the different subspecialty of infectious diseases. . . Therefore, the record reflects that Dr. Markowitz devoted the majority of his professional time to

> the 'active clinical practice' of defendant's internal medicine 'specialty.' The statute does not require more.
>
> We decline defendant's invitation to graft a requirement for matching subspecialties onto the plain 'specialty' language of MCL 600.2169(1). By holding plaintiff's expert witness to a higher standard than the statute required, the trial court demonstrated its misapprehension of the law. Accordingly, the trial court abused its discretion when it struck Dr. Markowitz's testimony." (Appendix, pp. 124a-125a)

The unmistakable implication from this ruling is that the Court of Appeals concluded, **without any explicit analysis of the language of MCLA § 600.2169(1)(a)**, that both Dr. Kuligowski and Dr. Markowitz specialized in the "same specialty" within the meaning of MCLA § 600.2169(1)(a). In the following sections of this Argument, Defendant/Appellant Kuligowski will conduct a detailed analysis of the commonly understood meaning of the language of that statute. As this analysis will demonstrate, the Court's apparent lack of analysis led to the Court of Appeals' erroneous, though unstated and implicit, conclusion that Dr. Markowitz specialized in the same specialty as Dr. Kuligowski at the time of the occurrence involved in this litigation.

(1) What Is Meant By "Specializes"?

The term "specializes" includes the term "subspecializes." According to Random House Webster's Unabridged Dictionary (2001), the term "specialize" means: "to pursue some special line of study, work, etc.; have a specialty: **The doctor specializes in gastroenterology**." This definition was implicitly accepted by the Court of Appeals in Nippa v. Botsford General Hosp., 251 Mich.App. 664, 666, 651 N.W.2d 103, 105 (2002), in which the Court of Appeals states that Arnold Markowitz, M.D. "specializes in infectious diseases".

(2) Is A Subspecialty A "Specialty" Within The Meaning Of MCLA § 600.2169(1)(a)?

Within the commonly understood meaning of the term, a "subspecialty" is a "specialty."

For example, an internist who subspecializes in the heart, is commonly referred to as a "heart specialist" or a "specialist in cardiology." According to Random House Webster's College Dictionary (2001), the term "specialist" is defined in pertinent part as: "1. a person **devoted** to one subject **or to one particular branch of a subject or pursuit**. 2. a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." (emphasis added). This Court applied the second of these two definitions in the case of Cox ex rel. Cox v. Board of Hosp. Managers for City of Flint, 467 Mich. 1, 18, 651 N.W.2d 356, 365 (2002). According to Random House Webster's Unabridged Dictionary (2001), the term "specialize" means: "to pursue some special line of study, work, etc.; have a specialty: **The doctor specializes in gastroenterology**." (emphasis added). Significantly, the record of this case establishes that gastroenterology is a subspecialty of internal medicine. (Appendix, p. 49a).

A doctor or physician is a specialist on the basis of advanced training and expertise in a particular field of general medicine. Jalaba v. Borovoy, 206 Mich.App. 17, 22, 520 N.W.2d 349, 352 (1994). This definition is just as true of the socalled "subspecialist" as it is of a more generalized "specialist."

The fact that the commonly understood meaning of the term "specialist" also includes "subspecialist" is further demonstrated by the case of McQuire v. Wasvary, 2005 WL 159644, *5 (Mich.App., 2005)(application for leave pending). In that case, the Court of Appeals accepted defendant's argument that he was a "specialist" in the area of colon and rectal surgery, although it was undisputed that the area of colon and rectal surgery was a "subspecialty" of general surgery.

Perhaps most significantly, Michigan appellate decisions have commonly referred to the field of "infectious diseases" as a "specialty." Nippa v. Botsford General Hosp., 251 Mich.App. 664, 666, 651 N.W.2d 103, 105 (2002)(the Court of Appeals states that Arnold Markowitz, M.D.

"specializes in infectious diseases"); Moy v. Detroit Receiving Hosp., 169 Mich.App. 600, 603, 426 N.W.2d 722, 724 (1988)(Court of Appeals refers to one of the plaintiff's treating physicians as an "infectious disease specialist"); Ravenis v. Detroit General Hospital, 63 Mich.App. 79, 86, 234 N.W.2d 411, 415 (1975)(Court of Appeals refers to one of the defense experts as "a specialist in infectious disease"); Distefano v. Michigan Womens Health Institute, P.C., 1999 WL 33433523, *1 (Mich.App., 1999)(the Court of Appeals refers to one of the plaintiff's experts and two of the defense experts as "specialists in infectious diseases").

(3) What Is Meant By The Phrase "The Same Specialty"?

According to Random House Webster's College Dictionary (2001), the commonly understood meaning of "same" is "identical" and "no difference." The Random House Webster's Unabridged Dictionary (2001) provides this same definition, but elucidates the meaning even further. In particular, this dictionary compares the word "same" with the word "similar," stating that these two terms "agree in indicating a correspondence between two or more things." Nonetheless, this dictionary also explains the differences between the two words, as follows:

> "SAME means alike in kind, degree, quality; that is, identical (with): *to eat the same food every day*. SIMILAR means like, resembling, having certain qualities in common, somewhat the same as, of nearly the same kind as: *similar in appearance; Don't treat them as if they were the same when they are only similar*." (italics in original).

In short, the term "same" means that one thing is identical with something else in kind, degree and quality. In its commonly understood meaning, it does not refer to things that are merely similar or related, to things that merely resemble one another or have certain things in common, or to things which are nearly the same.

(4) Application To This Case.

The party offering expert testimony has the burden of showing that the expert has the necessary qualifications. Gilbert v. DaimlerChrysler Corp., 470 Mich. 749, 788, 685 N.W.2d

391, 412 (2004); Siirila v. Barrios, 398 Mich. 576, 591, 248 NW2d 171 (1976); Carlton v. St. John Hosp., 182 Mich.App. 166, 171, 451 N.W.2d 543, 546 (1989). Accordingly, in the instant case, the Plaintiff had the burden of proving that Dr. Markowitz "**specializes** at the time of the occurrence that is the basis for the action in the **same specialty** as" Dr. Kuligowski.

In order to resolve this issue, this Court first needs to define what is encompassed by the fields of practice known as "internal medicine" and "infectious diseases." An internist has a broader scope of practice than an infectious diseases specialist. (Appendix, pp. 61a-62a). A specialist in general internal medicine, or internist, will treat many different systems of the body. (Appendix, p. 47a). The systems treated by a general internist include the heart, gastrointestinal tract, infections, lungs, genital urinary tract, and kidneys. (Appendix, pp. 47a-48a). Indeed, Dr. Markowitz testified that one would be hard pressed to find a system that general internists do not deal with. (Appendix, p. 47a). A specialist in infectious diseases, on the other hand, sees a much broader base of infectious disease patients than the average internist. (Appendix, pp. 57a-58a).

Although internal medicine is an end point of formal studies for some physicians (Appendix, p. 51a), internal medicine can also serve as a pathway to subspecialties. (Appendix, p. 48a). Infectious diseases, cardiology (pertaining to the heart), gastroenterology (pertaining to the gastro-intestinal tract), pulmonology (pertaining to the lungs), critical care medicine, nephrology (pertaining to the kidneys), rheumatology (pertaining to the bones and joints), neurology (pertaining to the brain and nervous system), dermatology (pertaining to the skin), hematology (pertaining to the blood), and oncology (pertaining to cancer) are among the specialties which a physician may attain through further training following initial training and certification in internal medicine. (Appendix, pp. 48a-51a).

An infectious disease specialist usually starts his career as an internist and then takes additional training. (Appendix, pp. 48a-50a). This additional training includes such matters as

fevers, bacterial and viral infections, post-operative infections, wound infections, and how to use antibiotics. (Appendix, pp. 42a-43a). Dr. Markowitz, for example, completed additional sub-specialty training, a fellowship in infectious diseases, after completing his internal medicine residency, and before entering private practice in 1976 (Appendix, p. 51a).

Based upon the foregoing descriptions of the fields of internal medicine and infectious diseases, can it be said that the practice of "infectious diseases" is **identical** to the practice of general internal medicine? Can we say there is **no difference** between the practice of "infectious diseases" and the practice of general internal medicine? The answer to both of these questions is clearly "No." As noted above, the fields of general internal medicine and "infectious diseases" are different in terms of both scope and level of training. Moreover, the nature of the patient population seen by an infectious disease specialist would be different from that seen by a general internist. For example, an infectious disease specialist sees a much broader base of infectious disease patients than the average internist. (Appendix, pp. 57a-58a).

For all of these reasons, it would be both illogical and a poor use of language to claim that the specialties of general internal medicine and infectious diseases are "the same." These two fields may have something in common, but (as discussed above) this does not make them "the same." Similarly, referring to the field of infectious diseases as a "branch" of internal medicine does not prove that they are the same. A branch is still a branch, and it is not identical with the tree itself.

Accordingly, both the trial court and the Court of Appeals erred by concluding that Dr. Markowitz "specializes" in the "same specialty" as Dr. Kuligowski, within the meaning of MCLA § 600.2169(1)(a).

ARGUMENT II

THE COURT OF APPEALS CLEARLY ERRED BY HOLDING THAT A BOARD CERTIFIED INTERNIST WHO ADMITTEDLY SPENT MORE THAN 50% OF HIS ACTIVE CLINICAL PRACTICE IN THE SPECIALTY OF INFECTIOUS DISEASES WAS QUALIFIED PURSUANT TO MCLA § 600.2169(1)(b)(i) TO OFFER EXPERT TESTIMONY AGAINST DEFENDANT/APPELLANT KULIGOWSKI, A BOARD CERTIFIED INTERNIST, AS TO AN INTERNAL MEDICINE ISSUE WHICH DID NOT INVOLVE INFECTIOUS DISEASES AND/OR IN HOLDING THAT IN ENACTING MCLA § 600.2169(1)(b)(i), THE LEGISLATURE INTENDED THAT THE COURT LOOK NO FURTHER THAN THE BROAD "SPECIALTY" OF THE EXPERT AND DEFENDANT, IGNORING WHETHER THE ACTIVE CLINICAL PRACTICE OF THE PROFFERED EXPERT FALLS WITHIN THE SAME "SUB-SPECIALTY" OF THAT BROAD "SPECIALTY" AS THE PRACTICE OF THE DEFENDANT AT ISSUE IN THE CASE.

A. Standard of Review

Like the issue addressed in Argument I, this issue is one of statutory construction. Accordingly, as discussed in Argument I, the de novo standard of review must applied to this issue.

B. Analysis

MCLA § 600.2169(1)(b) required the Plaintiff to prove that Dr. Markowitz satisfied the following criteria:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> . . . .
>
> (b) Subject to subdivision (c), **during the year immediately preceding the date of the occurrence** that is the basis for the claim or action, **devoted a majority of his or her professional time to** either or both of the following:
>
> (i) **The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.**

> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

The Plaintiff has never claimed that Dr. Markowitz satisfied the requirements of MCLA § 600.2169(1)(b)(ii). The only question is whether he satisfies the criteria specified in MCLA § 600.2169(1)(b)(i).

(1) What Is Meant By The Term "Active", As Used In MCLA § 600.2169(1)(b)(i)?

The term "active", is commonly understood to refer to: "1. engaged in action or activity; characterized by energetic work, motion, etc.: an active life. 2. being in existence, progress, or motion: active hostilities." Random House Webster's College Dictionary (2001). It is "characterized by current activity, participation, or use: active member." Random House Webster's College Dictionary (2001). The term is opposed to "passive." Random House Webster's College Dictionary (2001).

Based upon the foregoing definitions, in the context of MCLA § 600.2169(1)(b)(i), the term "active" refers to the witness' activity or work, as opposed to mere passive participation in a field of endeavor. This term would, therefore, exclude physician's whose actual activity in the specialty has been interrupted by such factors as retirement, sabbatical, health issues, and change of interest.

(2) What Is Meant By The Phrase "Clinical Practice", As Used In MCLA § 600.2169(1)(b)(i)?

In pertinent part, the term "clinical" is commonly understood as "1. pertaining to a clinic. 2. concerned with or based on actual observation and treatment of disease in patients rather than experimentation or theory." Random House Webster's College Dictionary (2001). Dorland's

Illustrated Medical Dictionary (26th Edition) defines this term as: "pertaining to a clinic or to the bedside; pertaining to or founded on actual observation and treatment of patients, as distinguished from theoretical or basic sciences." Along the same lines, Stedman's Medical Dictionary (27th Ed. 2000)(hereafter "Stedman's") defines "clinical" as: "Relating to the bedside treatment of a patient or to the course of the disease. 2. Relating to the observed symptoms and course of a disease." Stedman's defines "clinical medicine" as "The study and practice of medicine based on direct observation of patients."

The related term "clinician" is defined in Stedman's as: "A health professional engaged in the care of patients, as distinguished from one working in other areas."

In short, the phrase "clinical practice" refers to a health professional's personal and direct participation in patient observation and treatment. By way of example, the phrase "clinical practice" would not include administrative activities, animal research, theoretical activities, the authoring of articles and books, the review of medical/legal matters as a non-treating physician, and testimony in medical/legal matters as a non-treating physician.

(3) What Is Meant By The Phrase "That Specialty", As Used In MCLA § 600.2169(1)(b)(i)?

As already discussed in Argument I, a "subspecialty" is a "specialty" in the commonly understood meaning of the terms.

The term "that" refers to something previously mentioned. Random House Webster's College Dictionary (2001). In the context of MCLA § 600.2169(1)(b)(i), it can only refer to the specialty of the person against whom, or on whose behalf, the testimony is offered. In this case, the phrase would refer to Dr. Kuligowski's specialty of general internal medicine.

(4) Application To This Case.

During the year preceding the occurrence involved in this case, did Dr. Markowitz devote a majority of his professional time to the "active clinical practice" of general internal medicine

within the meaning of MCLA § 600.2169(1)(b)(i)? Stated another way, during the year preceding the occurrence involved in this case, did Dr. Markowitz devote a majority of his professional time to being a general internal medicine clinician? Again, the answer is "No." Although Dr. Markowitz was board certified in internal medicine, his practice in that field had for many years constituted far less than the majority of his professional time. The testimony of Dr. Markowitz demonstrates that, for many years preceding the alleged malpractice, he devoted a majority of his professional time to the active clinical practice of the specialty of infectious diseases. Dr. Markowitz strived mightily to confuse the true issue, by claiming that his clinical practice of the specialty of infectious diseases also constituted the clinical practice of internal medicine, but this was nothing more that a conceptual smoke screen. By virtue of training and scope, a focus on the specialty of infectious diseases is not the same as the active clinical practice of general internal medicine. As indicated above, both the training and scope of "infectious diseases" is different from the training and scope of the specialty of "internal medicine." The specialty of internal medicine is not the same as the specialty of infectious diseases. During the vast majority of his professional time, when he is focused on the field of infectious diseases, he is not engaged in the "active" clinical practice of general internal medicine. By definition, internal medicine is a broad area covering multiple bodily systems. The active clinical practice of general internal medicine would necessarily require a broad range of experience, not a narrow one. In order to focus his activity in the field of infectious diseases, Dr. Markowitz necessarily had to diminish his activity in the broad field of general internal medicine. Dr. Markowitz may have devoted the majority of his professional time to the clinical practice of medicine, but not in the field of general internal medicine. Rather, the majority of his professional time was devoted to the clinical practice of infectious diseases. Of necessity, Plaintiff/Appellee's assertions to the

contrary cannot be accepted without ignoring the commonly understood meanings of the terms used by MCLA § 600.2169(1)(b).

Moreover, as a matter of sheer logic, it makes no sense to argue that a physician can devote himself to general internal medicine (a field which Dr. Markowitz himself agrees is a broad encompasses numerous bodily systems within its scope) by narrowing his or her scope of practice.

The voir dire of Dr. Markowitz established that the majority of his professional time was "devoted" to the clinical practice of infectious disease medicine, and not general internal medicine as practiced by Defendant/Appellant Kuligowski. Dr. Markowitz testified that the breakdown in his practice has been essentially the same since he began practice in 1976 (Appendix, p. 51a-52a), with roughly equal or lesser amounts of time spent in the office than at the hospital:

> Q. You said your practice is half – half the time you spend in the office?
> A. Right.
> Q. How many hours is that?
> A. That's three days a week part-time, so probably 15, 20 hours a week.
> Q. Fifteen, 20 in the office. And then how many hours do you spend in the hospital per week?
> A. It varies -- It's -- as a consultant its whatever I'm called, so it can be from 15 to 50 or so. (Appendix, p. 52)
>
> . . . .
>
> Q. Doctor, in this pattern of practice that has remained essentially the same since 1976, you spend half or more of your time at the hospital, true?
> A. I believe so, yes. (Appendix, p. 57a)

Dr. Markowitz further testified that of the time spent in the office, about half of that was with general internal medicine patients, and the other half with infectious disease patients:

> Q. Your testimony was half the time that you spend in the office is seeing patients whose emphasis is internal

medicine in the broader scope and half is treating patients whose emphasis is infectious disease?

A. About, yeah. (Appendix, p. 53a)

Dr. Markowitz admitted that approximately 95% of the patients he sees in the hospital setting are infectious disease patients (Appendix, pp. 57a-58a). Counsel also confronted Dr. Markowitz with several depositions he had in other cases which were marked as Exhibits 26 - 29, and read in part into the record herein without objection (Appendix, pp. 67a-68a), in which cases, while being offered as an expert in infectious diseases, Dr. Markowitz minimized the amount of time he spent in the office on general internal medicine matters to 6 or 8 hours a week (Appendix, p. 69a), and repeatedly admitted that the large majority of his hospital practice was infectious disease consultations:

Q. Did you testify in the Eberts deposition that the ***majority of your practice was infectious disease?***

A. Yes.

Q. All right. Was it true when you said it?

A. ***It's still true.***

Q. Still true today?

A. Yeah. (Appendix, pp. 64a-65a)

. . . .

Q. Have you ever testified under oath to the following breakdown in the division of your practice between internal medicine and infectious disease, that you spent 12-15 hours a week in the office, half of which is Internal Medicine, half of which is infectious disease? You spend 40 hours a week in a hospital-based practice, 95% of which is infectious disease?

A. I think that's fundamentally what I said today. I think we went different hours in the office because I spend a little more time there now.

Q. So if I pull out a couple more depositions that said that, it would be unnecessary because your testimony today is you spend 95% of your hospital time in Infectious Disease?

A. That's correct. (Appendix, p. 65a)(emphasis added)

Based upon the foregoing testimony by Dr. Markowitz, there can be no genuine doubt that he devoted the clear majority of his active clinical practice to his specialty of infectious diseases, a specialty which is not relevant to any of the issues in this case, and which Dr. Markowitz did not share with Dr. Kuligowski. Accordingly, as the lower court properly concluded, Dr. Markowitz did not fulfill the requirements of MCLA § 600.2169(1)(b)(i).

As noted above, this is a case which does not involve any infectious disease issues (as conceded by Plaintiff's counsel, Appendix, pp. 87a-88a, 95a). Plaintiff/Appellee's selection of Dr. Markowitz as her sole "standard of care" expert witness is therefore puzzling. Dr. Markowitz was offered as an expert witness against Defendant/Appellant Mark Kuligowski, D.O., whose practice encompasses general internal medicine, and in this specific instance, was the regular treating physician to Plaintiff/Appellee's Decedent, Rosalie Ackley, age 73, at a time when she made office complaints of left arm pain and weakness. It was Dr. Markowitz's claim that Dr. Kuligowski, as a general internal medicine clinician, should have identified that Ms. Ackley was at high risk for a stroke, undertaken a prompt work-up for stroke, and made an urgent referral, rather than scheduling her for testing several days later on an outpatient basis. There is nothing in Dr. Markowitz' infectious disease training which equips him to address the standard of practice applicable to a general internist under the facts of this case. Dr. Markowitz is precisely the type of expert whose testimony was meant to be excluded by MCLA § 600.2169(1)(b)(i).

The holding of the Court of Appeals in this case was based upon the faulty premise that the Legislature did not mention subspecialties in MCLA § 600.2169, and therefore the Legislature did not intend to require matching subspecialties as one of the criteria under MCLA § 600.2169(1)(b)(i). Basically, the Court reached the conclusion, without any apparent analysis whatsoever, that the "plain meaning' of the undefined term "specialty" as a matter of law excluded "subspecialties", and held that for purposes of all subsections of MCLA § 600.2169, all

that the Legislature required was a matching of broad primary specialties. Remarkably, the Court never conducted any analysis of the plain meaning of the term "specialty." As disclosed above, a "subspecialty" is a "specialty." Accordingly, there was no need for the Legislature to specifically include subspecialties within the wording of MCLA § 600.2169. That term was already encompassed within the commonly understood meaning of the term "specialty."

In other words, the holding of the Court of Appeals is not warranted by the language of MCLA § 600.2169(1)(b)(i), runs contrary to the common understanding as to what constitutes a medical specialty, and as applied to the case at bar, completely defeats the purpose of MCLA § 600.2169(1)(b)(i), which is "to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying", Tate v Detroit Receiving Hospital, 249 Mich App 212, 218 - 219, 642 NW2d 346 (2002).

Plaintiff/Appellee has argued that the trial court confused "specialty" with "subspecialty", and that any physician who is board certified in internal medicine may testify against any other physician who is board certified in internal medicine, regardless of whether the majority of either the expert or defendant internist's "active clinical practice" is actually dedicated to one of the many areas of specialization which can proceed from initial training and certification in internal medicine, but without board certification in that sub-specialty.

As noted above, the Court of Appeals Opinion in this matter concurred with this argument, erroneously holding as follows in arbitrarily and broadly creating its own definition of "specialty":

> "In this case, defendant specialized in internal medicine, with a special emphasis on geriatric medicine. Dr. Markowitz also specialized in internal medicine, he simply focused on the different subspecialty of infectious diseases. Dr. Markowitz carefully explained, and plaintiff confirmed with documentation, that the subspecialty "infectious diseases" was a more focused application of internal medicine, but internal medicine nonetheless. He repeatedly explained that his practice was still entirely within the

> ambit of internal medicine. Defendant makes much of Dr. Markowitz's testimony that an "internist has a broader scope" of practice and he was "not sure what the average internist sees day in or day out." These statements were taken out of context from Dr. Markowitz's attempts to explain his use of his specialty and refrain from making speculative comparisons of his practice to the practice of other internists with varying subspecialties. He testified that all his patients saw him because of his status as a specialist in internal medicine. He explained that an infectious-diseases subspecialty merely allowed him to do more for his patients than the internal medicine specialty could alone. Defendant did not dispute this testimony. Therefore, the record reflects that Dr. Markowitz devoted the majority of his professional time to the "active clinical practice" of defendant's internal medicine "specialty." The statute does not require more.
>
> We decline defendant's invitation to graft a requirement for matching subspecialties onto the plain "specialty" language of MCL 600.2169(1). By holding plaintiff's expert witness to a higher standard than the statute required, the trial court demonstrated its misapprehension of the law. Accordingly, the trial court abused its discretion when it struck Dr. Markowitz's testimony."

This ruling was both legally and factually erroneous. There is no factual basis for finding that Dr. Markowitz actually devoted the majority of his active clinical practice to the specialty at issue herein, general internal medicine.

Contrary to the Court of Appeals' simplistic ruling that in its essence holds that a physician spending a majority of his or her active clinical practice in any area or combination of areas of the broad field of internal medicine qualifies that physician to testify against any other internist, the purpose of MCLA § 600.2169(1)(b)(i) is to ensure that the expert actually has the practical background to testify as to the specialty at hand, and to that end, what is at issue under MCLA § 600.2169(1)(b)(i) is matching the nature of the active clinical practice of the defendant doctor at the time of the alleged malpractice, and the nature of the active clinical practice of the proposed expert, where neither is board certified in a sub-specialty.

A simple example of the fallacy of Plaintiff/Appellee's position is that its construction of MCLA § 600.2169(1)(b)(i) would, in the context of board certified general internists, allow Dr.

Markowitz, whose "active clinical practice" is devoted to infectious disease, to testify not only against general internists such as Defendant/Appellant Kuligowski, but also against any board certified internist whose active clinical practice was devoted to cardiology, gastroenterology, pulmonology, nephrology, urology, rheumatology, neurology, dermatology, hematology, and/or oncology, as long as the defendant physician was not board certified in that specialty and the expert testified that he was familiar with the applicable standard of care.

Viewed another way, as Dr. Markowitz is not board certified in the specialty he admits a majority of his clinical practice is devoted to, infectious disease, under the Court of Appeals' "internal medicine is internal medicine" analysis, Dr. Kuligowski would similarly be qualified under MCLA § 600.2169(1)(b)(i) to testify against Dr. Markowitz in a case involving one of Dr. Markowitz's infectious disease patients, as Plaintiff/Appellee and Dr. Markowitz assert that is simply the practice of internal medicine for purposes of MCLA § 600.2169(1)(b)(i). Defendant/Appellant would submit that the trial court correctly applied MCLA § 600.2169(1)(b)(i), and the Plaintiff/Appellee's and Court of Appeals' interpretation of same is illogical, inconsistent with existing case law, and would lead to absurd results inconsistent with legislative intent, as suggested in the above examples.

Plaintiff/Appellee and Judges of the Court of Appeals argued that the omission of the term "subspecialty" from MCLA § 600.2169 is significant, citing a completely unrelated statute, MCLA 333.17001(1)(a)(ii)(A), a definitional section regarding licensure of academic institution hospitals which simply references residency programs in a "subspecialty of medical practice", as making clear that the Legislature was aware of and understood "the primary medical specialties and their sub-specialties", (Appeal Brief, p 10). 333.17001(1)(a)(ii)(A) was apparently enacted in 1978, and amended in 1990, and addresses occupational licensing. This provision has nothing

whatsoever to do with the tort reform amendments to the Revised Judicature Act enacted in 1993, which include MCLA § 600.2169 as set forth above.

As set forth in preceding arguments, the omission of a definition of "specialty" in the statute requires that term be construed by its commonly understood meaning, which for purposes of MCLA § 600.2169(1)(b)(i) would require the matching of active clinical practices in either a broad specialty or what Plaintiff/Appellee and the Court of Appeals refer to as subspecialties as the facts of the case would dictate.

In a case cited by both parties, the trial court and the Court of Appeals, Tate v Detroit Receiving Hospital, 249 Mich App 212, 218 - 219, 642 NW2d 346 (2002), the Court of Appeals made clear that the legislative purpose of MCLA § 600.2169 generally was "to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying". In Tate, the issue was whether a Defendant board certified in three different specialties could demand that Plaintiff file three separate Affidavits of Merit from Plaintiff experts in all three of those three same Board Certifications when only one of the three Board Certifications, in that case internal medicine, was at issue. In reversing the trial court, and holding that it would be unfair to require Affidavits of Merit in specialties not at issue in the case, the Court of Appeals held as follows:

> The primary goal in statutory interpretation is to determine and give effect to the intent of the Legislature. Nawrocki v Macomb Co Rd Comm'n, 463 Mich 143, 159; 615 NW2d 702 (2000). Courts must look to the plain and unambiguous language of a statute and can only go beyond the statutory language if it is ambiguous. *Id.* In such cases, this Court must seek to give effect to the Legislature's intent through a reasonable construction, considering the purpose of the statute and the object sought to be accomplished. Macomb Co., Prosecuting Attorney v Murphy, 464 Mich 149, 158; 627 NW2d 247 (2001).
>
> Subsection 2169(1)(a) specifically states that an expert witness must "specialize[] at the time of the occurrence that is the basis for the action" in the same specialty as the defendant physician. The

> statute further discusses board-certified specialists and requires that experts testifying against or on behalf of such specialists also be "board certified in that specialty." The use of the phrase "at the time of the occurrence that is the basis for the action" clearly indicates that an expert's specialty is limited to the actual malpractice. Moreover, the statute expressly uses the word "specialty," as opposed to "specialties," thereby implying that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold. Indeed, McDougall, 461 Mich at 24-25, states that "the statute operates to preclude certain witnesses from testifying solely on the basis of the witness' lack of practice or teaching experience in the *relevant* specialty." (Emphasis added.)
>
> The trial court in this case failed to correctly interpret and apply the provisions of §2169. In fact, we find that the trial court's strained reading of the statute actually defeats its true purpose. The Legislature's intent behind the enactment of §2169 is clear. As pointed out by our Supreme Court in McDougall, 461 Mich at 25, n 9, quoting McDougall v Eliuk, 218 Mich App 501, 509, n 1; 554 NW2d 56 (1996) (Taylor, P.J., dissenting), the Legislature enacted §2169 to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying. In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists the expert witnesses actually practice in the same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns."
>
> McDougall v Schanz further suggests that §2169 exists to ensure that "proof of malpractice 'emanate from sources of reliable character as defined by the Legislature.'" McDougall v Schanz, 461 Mich at 36, quoting McDougall v Eliuk, 218 Mich App at 518 (Taylor, P.J., dissenting). Tate, supra, at 217 – 220 (emphasis added).

This emphasis upon an expert witness actually having to practice in the same specialty as the defendant physician is even more clear in the language of MCLA § 600.2169(1)(b)(i), in its emphasis upon the "active clinical practice":

> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

In Decker v Flood, 248 Mich App 75, 638 NW2d 163 (2002), a case cited by Defendant/Appellant and relied upon by the trial court, the Court of Appeals held that a specialist may not testify against a defendant who has a more general practice in nature. The Defendant in Decker was a general dentist being sued for the performance of a root canal procedure. The expert witness against him was an endodontist, who, while also licensed as a general dentist, limited his practice solely to the performance of root canals. The Court in that case evaluated the issue of "specialists" and general practitioners who may technically practice within the same general discipline of medicine and noted that one who limits their practice to a specific area may not then be considered a generalist for purposes of giving expert testimony against a generalist, holding as follows:

> Here, plaintiffs claim that their expert, Dr. Gallagher, meets the qualifications of MCL 600.2169(1) because both defendant and Dr. Gallagher are general practitioners who perform root canals, with the only difference being that Dr. Gallagher limits his practice to root canals. Plaintiffs' argument requires an interpretation of the meaning of the concept "general practitioner" in the statute. Because this term is not defined in the statute and does not appear to be a technical term, we look to its plain and ordinary meaning. Western Michigan Univ Bd, *supra* at 539. The term "general practitioner" is commonly defined as "a medical practitioner whose practice is not limited to any specific branch of medicine." *Random House Webster's College Dictionary* (1997). By contrast, the term "specialist" is defined as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." *Id.* n5
>
> n5 Specialist is also defined as "one who devotes professional attention to a particular specialty or subject area." *Stedman's Medical Dictionary* (26th ed).
>
> It is apparent from plaintiffs' admission that because Dr. Gallagher "limits his practice" to root canals, he does not meet the definition of a general practitioner and is, in fact, a specialist. Further, it was undisputed that Dr. Gallagher is an endodontist, which is defined as "one who *specializes* in the practice of endodontics." *Stedman's Medical Dictionary* (26th ed) (emphasis added). Applying the ordinary meaning of general practitioner as one who does not limit his practice to any particular branch of medicine, Dr. Gallagher clearly does not satisfy the requirements of MCL 600.2169 and,

> therefore, would not be qualified to offer expert testimony on the standard of practice of a general practitioner, such as defendant Dr. Flood. Because Dr. Gallagher is precluded by MCL 600.2169 from testifying regarding defendant's standard of practice, there is no genuine dispute that the affidavit of merit attached to plaintiffs' complaint does not comply with the requirements of MCL 600.2912d(1), and defendants were entitled to judgment as a matter of law. Decker v Flood, 248 Mich App 75, 82-84, 638 NW2d 163 (2002)

Similarly, both Dr. Kuligowski and Dr. Markowitz are board certified internists as Dr. Gallagher and Dr. Flood were both dentists. However, the appellate courts have recognized the distinction in the practice of healing arts where there are distinctions of importance and the creation of certain specialties in health care professions. Accordingly, Decker, supra, is squarely on point in this case rendering Dr. Markowitz unqualified given the fact that he spends the majority of his time as an infectious disease "specialist" as opposed to Dr. Kuligowski who is a general internist.

As set forth in great detail in the "Statement of Facts and Proceedings", supra, the record is replete with admissions by Dr. Markowitz that the majority of his active clinical practice is devoted to infectious disease consultations, a recognized area of specialization in which, as the Court of Appeals previously held, Dr. Markowitz specializes in but is not board certified in:

> Although Dr. Markowitz specializes in infectious disease, he is not board-certified in this area of medicine. Nippa v Botsford Gen. Hosp, 251 Mich App 664, 666 651 NW2d (2002).

Where Plaintiff/Appellee does not seriously dispute that a majority of Dr. Markowitz's clinical practice is devoted to infectious disease consultations, it cannot seriously be argued that the trial court erred factually when it held "it's apparent that he does not practice the majority of his time in the field of internal medicine but rather in the field of infectious disease." Dr. Markowitz' own testimony demonstrates that he did not, and does not, devote a majority of his professional time to the clinical practice of general internal medicine:

Q. Did you testify in the Eberts deposition that the ***majority of your practice was infectious disease?***
A. Yes.
Q. All right. Was it true when you said it?
A. ***It's still true.***
Q. Still true today?
A. Yeah. (Appendix, pp. 64a-65a)

In the Court of Appeals, the Plaintiff/Appellee argued that construction of MCLA § 600.2169 which would preclude a specialist from testifying against a general practitioner where both are board certified in internal medicine would lead to "absurd" results. In Decker v Flood, 248 Mich App 75, 85, 638 NW2d 163 (2002), the Court of Appeals held:

> We find no absurdity or unreasonableness in the requirement that the qualifications of a purported expert match the qualifications of the defendant against whom that expert intends to testify.

As stated in Tate v. Detroit Receiving Hosp., 249 Mich.App. 212, 218-219, 642 N.W.2d 346 (2002), the Court has made clear that the legislative purpose of MCLA § 600.2169 generally was "to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying".

In the case at bar, application of these principles required that Dr. Markowitz not be allowed to offer expert testimony as to the standard of care for a general internist where he admittedly does not devote the majority of his "active clinical practice [to] that specialty", but rather, as the Court found in Nippa, "Dr. Markowitz specializes in infectious disease". This is far from a meaningless distinction, as Dr. Markowitz admitted upon voir dire that there are in fact distinctions in the patients he sees in infectious disease consultations, and what a general internist may see, admitting "I'm not sure what the average internist sees day in or day out" (Appendix, p 35).

Defendant/Appellant would submit that this distinction is particularly meaningful in the context of the case at bar, where the issue is whether the standard of care for a general internist

when presented with the set of complaints this elderly patient had required immediate testing and referral as claimed by Dr. Markowitz, or testing as ordered by Defendant/Appellant Kuligowski. Dr. Markowitz admitted that he was not aware of "what the average internist sees day in or day out", and it was not established that he was aware of how often elderly patients present with such complaints, the level of concern such complaints should evoke in a general internist who sees such complaints on a regular basis, or what the standard of care required in that circumstance.

Plaintiff/Appellee's argument adopted by the Court of Appeals that the trial court erred in its interpretation of the term "specialty" in a practical, as opposed to a hyper-technical manner based upon "off the record" nuances of "sub-specialty certification" and/or "certificates of added qualifications" is inconsistent with the actual language of MCLA § 600.2169(1)(b)(i), which makes no reference to "certification", and is further inconsistent with existing case law, as Decker v Flood, supra, referred to dictionary definitions, not Board publications, in defining "specialist" as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." and "one who devotes professional attention to a particular specialty or subject area."

Such argument is also inconsistent with logic and the legislative purpose of 600.2169(1)(b)(i), "to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying", Tate, supra. As noted supra, in the context of board certified internists without "sub-specialty certification" and/or "certificates of added qualifications" in the area of medicine that the Defendant physician devotes the majority of his "active clinical practice" to, Plaintiff/Appellee's argument would allow any board certified internist to testify against any board certified internist whose active clinical practice was devoted to cardiology, gastroenterology, pulmonology, nephrology, urology, rheumatology, neurology, dermatology, hematology, and/or oncology, so long as the defendant physician was not board

certified in that specialty, and regardless of whether the proposed expert devotes any portion of their active clinical practice to that same clinical specialty, so long as the proposed expert devotes the majority of his or her clinical practice to some form of internal medicine and claims to know the applicable standard of care.

In MCLA § 600.2169(1)(b)(i), the legislature has appropriately determined that such testimony must come from a physician who not only is board certified in internal medicine, but who also devotes the majority of his "active clinical practice [to] that specialty". As the Court found in Tate v Detroit Receiving Hospital, supra, at 218 - 219, the legislative purpose of MCLA § 600.2169 was "to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying". Such firsthand practical experience, in the judgment of the legislature, is established by a showing that the expert devotes the majority of his "active clinical practice [to] that specialty", and a failure to so demonstrate bars the witness from testifying, irrespective of board certification. McDougall v Schanz, 461 Mich. 15, 597 N.W.2d 148 (1999); Decker v Flood, supra. Such showing "will protect the integrity of our judicial system by requiring real experts instead of 'hired guns'", and ensure that "proof of malpractice 'emanate from sources of reliable character as defined by the Legislature'", Tate, supra, quoting McDougall, supra.

Plaintiff/Appellee having failed to establish that Dr. Markowitz was qualified to testify pursuant to MCLA § 600.2169(1)(b)(i), the trial court did not err in granting Defendant/Appellant's motion to strike Dr. Markowitz as a standard of practice expert pursuant to MCLA § 600.2169(1)(b)(i). Quite the contrary, it would have been manifest error if the trial court had allowed Dr. Markowitz to testify regarding the standard of practice applicable to a specialist in general internal medicine.

Accordingly, Defendant/Appellant prays that this Court issue an Opinion reversing the Court of Appeals, and reinstating the directed verdict granted by the trial court.

ARGUMENT III

THE COURT OF APPEALS CLEARLY ERRED BY HOLDING THAT ARNOLD MARKOWITZ, M.D., WHO HOLDS HIMSELF OUT AS AN INFECTIOUS DISEASE SPECIALIST, WAS QUALIFIED TO OFFER TESTIMONY IN THIS MATTER WHERE (1) THE WITNESS ADMITTED THAT HE WAS "NOT SURE WHAT THE AVERAGE INTERNIST SEES DAY IN OR DAY OUT", AND (2) NO TESTIMONY WAS OFFERED TO ESTABLISH THAT DR. MARKOWITZ WAS FAMILIAR WITH THE STANDARD OF CARE APPLICABLE TO A SPECIALIST IN GENERAL INTERNAL MEDICINE.

A. Standard of Review

An appellate court reviews for an abuse of discretion a trial court's rulings regarding the qualifications of proposed expert witnesses to testify regarding the specifics of the standard of care and whether the standard has been breached. Cox ex rel. Cox v. Board of Hosp. Managers for City of Flint, 467 Mich. 1, 16, 651 N.W.2d 356, 364 (2002); Bahr v. Harper-Grace Hospitals, 448 Mich. 135, 141, 528 N.W.2d 170, 173 (1995).

B. Analysis

In its Opinion in this matter, the Court of Appeals erroneously held as follows:

> Defendant makes much of Dr. Markowitz's testimony that an "internist has a broader scope" of practice and he was "not sure what the average internist sees day in or day out." These statements were taken out of context from Dr. Markowitz's attempts to explain his use of his specialty and refrain from making speculative comparisons of his practice to the practice of other internists with varying subspecialties.

To the contrary, Defendant/Appellant went to great lengths in its Counter-Statement of Facts to quote this testimony in full context, as it has in the present appeal.

Dr. Markowitz admitted that in his specialty of handling consultations to see infectious disease patients, he sees a broader base of infectious disease patients, but that the average internist sees a broader scope of patients than he does, so much so that he admitted that "I'm not sure what the average internist sees day in or day out":

"Q. I want to remind the judge of two statements that you made this morning, and I want you to tell me if you said this and if it was accurate?

A. Okay.

Q. Your ***hospital practice is primarily infectious disease***, did you say that this morning?

A. Yes, I did.

Q. Did you say the internist has a broader scope of practice?

A. ***The internist has a broader scope, yeah***, I believe he does, yeah --" (Appendix, pp. 61-62)

. . . .

Q. You'll agree with me that day in and day out you see a much broader base of infectious disease patients than you would expect the average internist to see?

A. Well, I couldn't argue that. I see patients for surgeons that internists wouldn't see, that's true.

Q. You see a much broader base of limited infectious disease issues in your practice than the average internist would, do you agree?

A. Well, not necessarily. ***I'm not sure what the average internist sees day in or day out.*** I know what I see day in and day out. We see basically the same kinds of patients. I guess I see them sometimes when they have been seen by a surgeon instead of a surgeon or OB-GYN guy, but ***most of them are internal medicine patients who happen to have infectious diseases. The internists sees them this morning, I see them a couple hours later.*** I think most of my consults actually are with internal medicine physicians.

Q. But the Internal Medicine Physician calls upon you for a specific purpose and that's infectious disease issues; 95% of your consultive practice at the hospital is Infectious Disease issue?

A. Right, but infectious disease doesn't preclude it being an internal medicine issue, which is infectious disease." (Appendix, pp. 57-58)

In addition, Defendant/Appellant argued to the Court of Appeals that a review of the examination of Dr. Markowitz at the trial of this matter discloses that Plaintiff/Appellee failed to establish the threshold qualification issue under MRE 702 that Dr. Markowitz was familiar with the applicable standard of care for a general internist in this situation, as required by Bahr v Harper-Grace Hosps. 448 Mich 135, 528 NW2d 170 (1995). The party offering expert testimony

has the burden of showing that the expert has the necessary qualifications. Gilbert v. DaimlerChrysler Corp., 470 Mich. 749, 788, 685 N.W.2d 391, 412 (2004); Siirila v. Barrios, 398 Mich. 576, 591, 248 NW2d 171 (1976); Carlton v. St. John Hosp., 182 Mich.App. 166, 171, 451 N.W.2d 543, 546 (1989).

The Court of Appeals erroneously avoided this threshold argument in its footnote two, by holding:

> While plaintiff's expert meets the requirements of the statute, he must still demonstrate that he can testify to the appropriate standard of care based on his "knowledge, skill, experience, training, or education . . . ." MRE 702. We leave adjudication of this undecided issue to the trial court.

Defendant/Appellant would submit that Plaintiff/Appellee was required in its proffer of Dr. Markowitz at the first trial in this matter to establish this related threshold issue of competency. Plaintiff failed to do so. The Court of Appeals clearly erred in relegating this issue to be decided on a different record on remand, where it should have been decided in the context of the present record and appeal.

Taken together with Dr. Markowitz's admission that "I'm not sure what the average internist sees day in or day out", the failure to establish that Dr. Markowitz was in fact aware of the applicable standard of care provided a mandatory basis for affirming the trial court ruling independent of MCLA § 600.2169, that being that Plaintiff/Appellee factually failed to qualify Dr. Markowitz pursuant to MRE 702.

By erroneously explaining away Dr. Markowitz's admissions, and/or relegating the issue of competency pursuant to MRE 702 to be determined upon a new record during a second trial on remand, the Court of Appeals clearly erred, as it is a basic principle that an appellate court should not reverse where the "right result is reached for the wrong reason", Glazer v Lamkin, 201

Mich App 432, 437, 506 NW2d 570 (1993); State Mutual Ins. Co. v Russell, 185 Mich App 521, 528, 462 NW2d 785 (1990).

RELIEF

For all of the foregoing reasons, Defendant/Appellant Kuligowski prays that this Honorable Court issue an Opinion and Order reversing the April 22, 2004 Opinion of the Court of Appeals, reinstating the trial court ruling that Arnold Markowitz, M.D. is unqualified to testify regarding the standard of practice applicable to Defendant/Appellant Mark Kuligowski, D.O., and reinstating the order of directed verdict entered by the trial court.

Respectfully Submitted,

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Dated: September 6, 2005

STATE OF MICHIGAN

IN THE SUPREME COURT

SHIRLEY HAMILTON, as Personal Representative of the Estate of ROSALIE ACKLEY, Deceased,

Plaintiff/Appellee,

v.

BLUE CROSS/BLUE SHIELD OF MICHIGAN,

Intervening Plaintiff,

v.

MARK F. KULIGOWSKI, D.O.,

Defendant/Appellant.

Supreme Court No: 126275
Court of Appeals No: 244126
Lower Court Case No: 00-033440-NH

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PROOF OF SERVICE

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DAWN A. HALLMAN, being first duly sworn, deposes and says that on September 6, 2005, she served a true copy of **Brief on Appeal of Defendant/Appellant Mark F. Kuligowski, D.O.**, along with this **Proof of Service** on:

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by placing said true copies in envelopes correctly and plainly addressed to the above noted parties and depositing said envelopes in the United States Mail with postage thereon fully prepaid.

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